approximately 6x5 cm. in extent and overlapped the centers for the left face and arm as well as the anterior end of the temporal lobe. A small portion of cortex was removed for microscopical examination, the fluid was evacuated from all the small cyst-like collections, and the wound was closed in layers. Throughout the operation bleeding from the diploë was extremely active and troublesome. In the absence of bone-wax it was necessary to leave several pledgets of cotton in the wound to control hemorrhage. The center of the wound was reopened on the 4th day and the cotton was removed: healing per primam throughout. The patient had one slight convulsion on the day following the operation with delirium and somnolence on the fourth day (no edema of discs), recovery otherwise not remarkable. There is at present no palsy of any muscle or the extremity and the reflexes are active, the astereognosis remains unchanged. There have been no further seizures.

On examination of the fragments removed, it was found that the band of dura removed was made up of thick strands of closely packed white fibrous tissue. The portion of cortex excised showed a practical absence of the normal cortical pyramidal cells and a considerable increase in glia elements—more especially the fibers. There were a few lymphocytes scattered through the specimen with a slight amount of old blood coloring matter. Dr. E. C. Dickson, at Lane Hospital, who kindly looked over a section for us, decided: "The appearance is rather that of old scar formation. There does not seem to be evidence of malignancy." The very considerable area involved, the late appearance of epileptiform seizures, and the very few discoverable physical signs, made the case especially interesting to us. The relief (for several months at least) from convulsions following removal of a thick fibrous dural band and the emptying of cyst-like subpial collections of fluid made it seem likely to us that the mechanical pressure may have been the causal agent in setting the epileptiform seizure in motion.

PROCEEDINGS OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY.

During the month of March the following meetings were held:

Section on Medicine, Tuesday, March 7th, 1911.

1—Sleeping Sickness and the Trypanosomes (with microscopical slides). Chas. A. Kofoid, Professor of Zoology, University of Calif. Discussed by Drs. McCoy, Wellman and Kofoid.

2—Parasites Affecting Man Observed in California (with lantern slides). Creighton Wellman. Discussed by Drs. Kofoid, McCoy, Alvarez and Wellman.

General Meeting, Tuesday, March 14th, 1911.

1—Discussion on Resolutions proposed by Committee on Contract Practice.

2—Aortic Regurgitation. Wm. Watt Kerr.

3—Two Cases of Intracranial Tumor cured by Operation. Leo Newmark, H. B. A. Kugeler, Harry M. Sherman. Discussed by Drs. McClenahan, Stillman, Rosenstirn, Castle, Newmark, Sherman.

Section on Surgery, Tuesday, March 21st, 1911.

1—Rectal Surgery under Spinal Anesthesia. B. F. Alden. Discussed by Drs. Newman, Barbat, Krotoszyner, Zobel, Morton, Tait, Alden.

2—Rectal Surgery under Local Anesthesia. A. J. Zobel. Discussed by Dr. Newman.

Eye, Ear, Nose and Throat Section, Tuesday, March 28th, 1911.

1—Demonstration of Cases. Harrington B. Graham.

2—Demonstration of Case. Cullen F. Welty.

3—"606" in Eye Disease. M. W. Frederick. Discussed by Drs. Barkan, Pischel, Bine, Frederick.

General Section, March 14th, 1911.

Dr. Harry M. Sherman exhibited a patient upon whom he had operated for endothelioma of the dura mater. The tumor removed was 6x8x4 cm., most of it being within the cavity of the skull, where it had made a large depression in the left frontal and prefrontal lobes. The only subjective symptoms of its presence were anosmia and some irascibility. After the removal of the tumor the brain gradually returned to its normal shape and size. A silver plate, oval in shape, about 4x6 cm. in size, was then put into the skull to fill the gap in the bone and restore the convexity of the frontal region.

Local Anesthesia in Rectal Surgery.

By ALFRED J. ZOBEL, M. D.

Local anesthesia is mainly of value in minor surgery. It is the general consensus of opinion among rectal surgeons that nearly 80% of all the affections of the ano-rectal region are conditions that require only a minor surgical procedure for their relief and cure; and that the great majority of these can be done under local anesthesia.

Many of these ano-rectal troubles give rise to pain, suffering, and discomfort out of all proportion to the extent or seriousness of the pathologic lesions present. It is therefore assumed that, if a simple operative procedure under a local anesthetic can affect as good, safe and speedy a cure as can be secured under a general anesthetic, patients need not be subjected to those dangers that always lurk in the latter, even when administered by a most experienced anesthetist; nor need they be caused the post-anesthetic discomforts and sufferings so often attendant thereon. Besides, in these modern days, any operative procedure that requires a general anesthetic means confinement, for a longer or shorter period in a hospital, with not only additional expense, but the dread attached thereto by the laity. As a result there flourishes in our midst the quack, the itinerant, and the "no knife" specialist.

It must not be misconstrued from this that general anesthesia is unnecessary in rectal surgery. Far from it. There are numerous important conditions where it is the only method of anesthesia that can be employed. It should be the anesthetic of choice in operations on complex or horseshoe fistulae; on recto-vaginal, recto-urethral or recto-vesical fistulae; or even in a simple fistula when one is not absolutely sure that it is straight and uncomplicated, and when it is of extended length.

It should be used for the removal of neoplasms requiring extensive dissection; in resections and excisions; and in operations on strictures or malformations above the anal canal.

It must be employed in operations high up in the rectum; where there is a small contracted anus; in cases of extensive prolapse; and where there is any doubt of the diagnosis, thereby making it uncertain how much of an operation might be necessary.

While incipient and small ischio-rectal abscesses may be opened under local anesthesia, a resort to general anesthesia is preferable if the abscess has attained any size; for it may be necessary to do more than was anticipated, before the source of the trouble is located.

The aforesaid conditions are the 20% of those that come to the rectal surgeon for relief, and these are emphasized as requiring general anesthesia.

In the other 80% are those conditions which can be easily, safely, and quickly operated on under a local anesthesia. This group includes internal hemorrhoids, fissures, and small simple straight fistulae, uncomplicated by other serious disease; external thrombotic hemorrhoids; cutaneous hemorrhoids; hypertrophied papillae; small anal strictures; inflamed crypts of Morgagni; polypi; ulcers; moderate degrees of prolapse; and marginal abscesses. These are the lesions we meet with most frequently; and these are the ones that only require a minor surgical procedure under a local anesthetic skillfully